



ALERT

News from the UFMCC on AIDS Legislation, Education, Research and Treatment.

THE CARTER CENTER CONFERENCE

JANUARY & FEBRUARY 1990
Editor: Rev. Steve Pieters

December 4, 1989, The Carter Center, Atlanta, GA: UFMCC was in the forefront of the U.S. Interfaith movement, when over one hundred religious leaders gathered to discuss a unified religious community response to the challenges posed by AIDS. The AIDS National Interfaith Network (ANIN), the Carter Center of Emory University, and the Atlanta Interfaith AIDS Network sponsored the historic consultation, AIDS - The Moral Imperative: A Call to National Leadership, at which participants discussed and signed on to the Atlanta Declaration, which calls for creative action from all institutions -- medical, social, economic, political and religious -- for the purpose of providing comprehensive attention to the HIV epidemic.

UFMCC's participants included Rev. Elders Troy Perry, Freda Smith, Don Eastman, Jeri Ann Harvey, Revs. T. Edward Helms, A. Stephen Pieters, E.J. Watkins and Karen Ziegler. Also attending as observers were the pastors of the two Atlanta MCC's, Rev. Steve Fund and Rev. Reid Christiansen.

The night before the conference, an Interfaith Service of Hope and Healing was held at the Episcopal Cathedral of St. Philip in Atlanta. Rev. Elder Don Eastman and Rev. Steve Pieters processed with the honorary host committee, and Rev. Pieters read scripture. The service was attended by close to 1000 people, and was given full coverage on most local television stations that night.

The consensus among the MCC delegation was that it was one of the most truly interfaith services any had attended, including elements of the Jewish, Hindu, and Christian traditions. The service featured glorious music sung by five different choirs, including a magnificent Jewish choir with an outstanding cantor, the Shirim Chorale; the choir of the host cathedral, garbed in full Elizabethan robes and hats; and a black gospel choir, the Morris Brown College Choir, which raised the roof off the cathedral. In the Episcopalian silence that followed, Rev. Elders Jeri Ann Harvey and Freda Smith were heard to shout "Hallelujah!" Methodist Bishop Leontine Kelly acknowledged and affirmed their shouts of praise when she began her powerful sermon.

As chair of the AIDS National Interfaith Network, Rev. Elder Don Eastman was highly visible and involved at every level of the Carter Center Conference. He was slated to introduce former President Jimmy Carter. Carter, however, was detained on a mission in Ethiopia, and Eastman introduced Dr. William H. Foege, Executive Director of the

Carter Center, who brought the President's message. Rev. Eastman presided over the conference with his usual professional and polished demeanor.

Also addressing the consultation were Presiding Bishop Edmond Lee Browning of the Episcopal Church, and June R. Osborn, M.D., Chairperson of the National Commission on AIDS and Dean of the University of Michigan School of Public Health.

Rev. Steve Pieters spoke on the panel of persons living with HIV/AIDS, and talked about UFMCC's journey with HIV/AIDS as well as his own. Sallie Perryman, also a member of the Board of Directors of ANIN, spoke movingly about her husband's life and death with AIDS, and her own feelings about being HIV+. Anna Mae Kattner, the mother of a gay man who died from AIDS, spoke about her experiences with her son and her church in rural Kansas. The first Executive Director of New York's Gay Men's Health Crisis, Mel Rosen, spoke passionately about his own experience of AIDS, and his observations about the lack of response from the majority of the Jewish community.

The Atlanta Declaration is as follows: "The Board of Directors of the AIDS National Interfaith Network, meeting in Atlanta, Georgia, on December 5, 1989, celebrates the action of the religious leaders gathered at the "AIDS: The Moral Imperative" Conference and their adoption of "The Atlanta Declaration." In addition, the Board of ANIN re-affirms its historic Mission Statement, which includes the declaration that: 'AIDS is not divine punishment. God's merciful, loving, and empowering presence is with all affected by disease, including AIDS/HIV infection.' Further, this Board expresses its recognition and affirmation of the care, compassion, advocacy and leadership of the Lesbian and Gay community in their courageous response to the AIDS pandemic."

If you have not already done so, you may add your individual, church, and/or organizations' endorsement by notifying Bill Johnson, M.Div.Ed.D., Executive Officer, ANIN, 475 Riverside Drive, 10th Floor, New York, NY 10115; 212/870-2100.

AIDS IN THE YEAR 2000

*By June E. Osborn, M.D.
(AIDS National Interfaith
Network Consultation)*

I am not much of a futurist, and the charge to anticipate vistas of the year 2000 has caused me considerable unease in the past. It still does -- but the peculiar traits of the human immunodeficiency virus make it unpleasantly easy to offer some predictions. As our insight sharpens, the median interval between onset of infection and advent of AIDS keeps growing longer. For a while there, during the past couple of years, the consensus about average time elapsed from infection with HIV to diagnosis of AIDS seemed to have settled at 7 years. The fragility of that figure was intuitively obvious, since the epidemic has been recognized for only 8 years; but I clung tightly to it, taking heart from modelers who seemed to reinforce the epidemiologists, and hoping that ongoing studies would soon show curves to be peaking or leveling off (or whatever).

I am afraid my optimism had the better of me, for recently it is becoming clear that the likely interval is 10 or even 11 years. Since that is the median interval, there will be many people who will take longer to become ill; indeed, there is good news from the AZT front that suggests that we may be able to extend the duration of asymptomatic HIV infection even further. And if all that is true, we aren't really being futurists when we discuss people who will be caught up in the epidemic by the year 2000. In point of fact, we are talking about people who became infected last week!

Of course, there is not as much information as one would like, ideally, to tell us how many of them there are. We have only general descriptive clues about who they are. On the positive side, we have the knowledge that might allow us to stop further spread next week, which would surely help matters. But what we know and can surmise warrants our collective anxiety that a decade may be barely enough time to prepare for the storm that glowers over the landscape of our society. AIDS is a photograph, a snapshot that takes at least 10 years to develop; and dark clouds already dominate the mood of the picture that has been taken.

Since you have had extensive discussion of medical care and preventive considerations, I want to talk about cultural, social and political features of the epidemic. I will focus remarks on the United States, but I want to point out that it should serve usefully if not admirably as a source of examples for countries around the world that are caught up in the same pandemic crisis, for we are reaping the whirlwind of our multicultural experiment. America was of course conceived as a haven for cultural diversity and was so brash a century ago as to reiterate its welcome to tired, poor, and huddled masses.

They came and most of them prospered, but not all. More recently it has become even more complex, only now the dynamics are those of boat people or refugees or so-called illegal aliens. By these various routes the experiences of America's people with HIV and AIDS are as diverse as humanity itself; and it has been the epicenter, the "trailblazer" in epidemic experience.

Unfortunately diversity is a looming fact of American life in economic as well as ethnic terms. Individualism and entrepreneurial energy characterized not only our industrial growth but also the development of our health care system. The best of that system is very good indeed, but at its weak spots it had already become patched and tattered before AIDS. In between the very rich and the very poor, arrangements for care were problematic, and the financing of care between those extremes depended to an overwhelming extent on employment related health insurance. That is not necessarily a bad idea in times of full employment, but these are not such times, and we have seen AIDS threaten to complete the investiture of an "under-class" in our once proudly class-less land of opportunity.

Furthermore, the fact that the medical care arrangements are better for the very poor has meant that HIV-infected members of the middle-class have had to "spend down into poverty" as they become ill, in order to qualify for grudging government programs that might finance the many months of care required in the twilight of their lives. This "rich-man, poor-man" tension in our health care system is about to be exacerbated still further, of course, as recommendations for use of AZT are pushed earlier and earlier in the course of HIV infection, and as such costly but effective clinical gambits as prophylactic pentamidine are added to our potential armamentarium. The clinical advances are wonderful news and the prospect that much can be done to improve the lives of HIV-infected persons is a remarkable advance from earlier desolate times; but the promise could be only a cruel tease for many people if we don't adjust our systems of care and financing to facilitate their access.

But back to social diversity for a bit longer: culturally, it has become unfashionable -- even unwise -- to refer to American society as a "melting pot"; for cultures don't seem to melt. Persons whose exploration of their roots unearth the tangled traces of slavery are just beginning to dig further to find taproots of a sustaining ethos. Better preserved and defined cultural identities are cherished by many of the peoples who contribute distinctively to our population. Well-meaning "anglos" are learning that sensitivity to one sort of Hispanic background may not serve well in dealing with another; and Americans whose personal histories trace far back into ancient Chinese or Japanese cultures find their collective grouping as "Asian Americans" to be startlingly superficial.

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AIDS in the Year 2000 (cont'd)

Indeed, we stand to benefit greatly if we can learn to celebrate our diversity; but in the meantime there is serious social trouble, for some of the immiscible elements of our multicultural population are sinking in a morass of poverty, illiteracy, hopelessness and heightened risk of drugs and HIV, and the extent to which that continues will go far to describe AIDS in the year 2000. It is in approximately that year that the so-called "majority" will become the minority in America.

What else can we say about the place of HIV in the social landscape of 2000? Well, there will be no further argument about whether AIDS is a disease of restricted "groups"; we will know that it is a sexually transmitted disease to which men, women and (above all) adolescents are susceptible and vulnerable. The apparent variations in efficiency of transmission that have received so much attention in our press will long since have scattered like straw men before the fact that with sexual activity, inefficiency doesn't matter since people do so much of it. Any kind of sexual intercourse seems to work when it comes to transmitting HIV; and so the focus will have turned, appropriately, to numbers of sexual partners and to self-protection against the virus, by use of condoms, spermicides or other measures yet to be devised.

[As a parenthetical aside, if one fails to mention sexual abstinence at the head of a list of preventive measures in the U.S., there is trouble, for the American Moralist is a ubiquitous species. But I find that a depressing and curious iteration. Proposing sexual abstinence in early adolescence is a family ethic; but proposing it as a durable solution to anything is rather astonishing to a biologist. I suppose, with fanciful enforcement proposals, universal abstinence could be entertained as a cataclysmic approach to overpopulation, but short of that it has little to do with the AIDS problem..].

As heterosexual spread becomes increasingly dominant, there will of course be greatly increased representation of women among the HIV-infected, and as surely as night follows day, there will be children. That is certain to force a rather dramatic shift in the dynamics of health care and social welfare in those epidemic areas where the initial preponderance of gay men masked the true universality of the virus. The dominance of men among the HIV-afflicted had been so striking in some areas of the U.S. the west coast and parts of the South, for instance, that when the first wave of bisexual cases appeared, it had impact out of all proportion to their numbers. It is a thorny enough problem to arrange for the employment, housing, social support and medical needs of single men in their twenties or thirties. The mournful fact of their episodic rejection by their "childhood" families has been mitigated by the loving care of their adult family, and inspiring new meaning has been given to the word

"community" in the unfolding of the AIDS tragedy within the gay community. The underlying inadequacy of care and treatment options has often been masked by volunteerism and mutual support.

Single adult men are challenge enough; but when illness and death pervade a whole multigenerational family unit it is a far different matter! and that is what is coming. In the parts of the U.S. where the virus has been present the longest the male:female ratio is approaching one-to-one. The AIDS snapshot is already in the developer and last year 1 in every 77 births in New York was to an HIV-infected mother. Where there are two parents in such a household, one or both may be ill, and employment-related health insurance becomes a frail source of care as chronic disease manifestations emerge. As often as not there is only one parent - the index case, already so ill that she is no longer a care-giver, much less a provider. New York is the scene of some horrendous vignettes: older children, unaffected because their birth order preceded maternal infection, left standing like lone surviving trees in a burned-out forest after parents and younger siblings have sickened and died. There are not many of these yet, but there are enough to warn - and it is a spectre to be conjured with in the future. Already we are groping for new terms to serve as synonyms for "orphanage" since the archaicism of that kind of institution is hard for us to accept, despite the growing need.

Of course all that means that there will be infected infants too, and pediatric AIDS is a horror that defies imagination. Anyone who has delighted at first-hand in the miraculous flowering of neurologic skills in a health infant must recoil at the very concept that developmental milestones once attained might yet be reversed and recede. The tortuous illness and death of a child must rank with the most profound of grievous losses. Yet by the end of the next two years AIDS (in our country) will begin to match, annually, the toll formerly exacted on children by congenital rubella. Some die fairly quickly, to be sure; but some seem to share the tedious fate of older infected persons, and the equivocation of their future is brutal in itself.

[Parenthetically I have come to believe that, in this epidemic, even that intensity of tragedy is matched or exceeded slightly by the loss that we have been suffering to AIDS of trained talent among young men and women who once were children but who have somehow lost their status in our affections, and with it, their claim to unqualified compassion. They seem to be excluded in the common mind from the groups referred to as "innocent victims" - which exclusion seems to be a tacit, fetid condemnation of sick people that could sicken society itself if it were allowed to fester for another decade.]

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AIDS in the Year 2000 (cont'd)

Neurologic and systemic disease of children is not the only harm; in our experience in the U.S., even when the children born to an HIV-infected mother have escaped infection themselves, they may be doomed by stigma, for the social ramifications of participation in this epidemic however indirect, have such force that an awful fraction of the 62,000 families in our country thus far suffering losses from AIDS have had to do even their grieving in secret! What a horror! And what a future to offer a child! I do not know how to avoid completely the occurrence of pediatric AIDS in the year 2000, for that is horrid graffiti that already may have been carved in stone. But at the very least we must protect those children from the ravages and pervasive costs of unwarranted fear!

I have yet to mention illicit drugs and all they portend for the future of the epidemic. If you accept my premise that - when we conjecture about AIDS in the year 2000 - we are talking about infections that happen now, then we know to expect trouble. In the U.S. the "just-say-no-or-else!" approach to the drug epidemic continues to prevail in the face of years of failure. To paraphrase my admired colleague Michael Kirby, we probably will not make headway against addictive drugs - or even slow their progress into the society - until we learn to approach that epidemic as a public health problem rather than a matter for the national guard, the courts and the police.

Our borders are too vast! We cannot build prisons fast enough! We cannot keep people in prison, drug-free, long enough! and our politicians cavil about the fact that needle-exchange trials will give us the appearance of "condoning" the use of illicit substances. But look what we are condoning instead! Suffice to say that present needle-sharing for intravenous heroin use is exceeded only by intravenous cocaine use - and soon perhaps both of those by sex-for-crack-cocaine - as conduits to a luxuriant future for the virus of AIDS. It will afflict the users and their non-using sexual partners and their children. It will afflict not only the addicted but the occasional user as well...and we have several million of those. The toll could be horrendous and will sweep up with special fury those who are now disadvantaged adolescents and children...especially those for the odds in life's game are so bad already that a 50:50 chance sounds like the best hand they've ever been dealt, when the "down" side relates to obscure events a few years hence! We must learn much about such kids that we do not presently know in order to intercept the virus along this pathway - and we will have to use sensitivity to communicate with people within those desperate communities if they - and we - are to have a chance of interrupting the inexorable spread of HIV. I was hopeful that a fresh look at the drug epidemic could provide new impetus to deal with the "demand side"; but the interface between drugs and AIDS is very poorly attended to in the current executive proposals, and the

National Commission on AIDS felt impelled to re-state the urgent recommendation of the Presidential Commission - that the availability of drug treatment on demand for addicts who seek it is fundamental to progress in the HIV epidemic.

Let me make a few more comments about culture and then a few about politics. We must take special care to assign to cultural diversity its proper value as this epidemic progresses, or the road taken to the year 2000 could be not only grim but bleak. I do not care to predict the outcome, for my anticipation depends on my mood - instead I will simply focus for a moment on some of the vector forces that will determine the ultimate direction.

Repressive reactions to AIDS have already been notable for their ability to distract the public from more useful efforts. It seems far easier to think about cordoning off peripheral segments of the population than to face squarely the implications of the facts of limited transmission and their corollative message about need for behavior change. A trivial but useful example may illustrate my point: there are so-called "singles" clubs in the United States where unattached adults can meet and "swing". With the advent of the HIV antibody test, some began to charge hundreds of dollars a year for a membership that included 6-monthly testing and issuance of certificates for negativity. Sort of like a service warranty, I guess. What an extraordinary combination of naivete and panache!

But the outcome of such simplistic thinking is not trivial and it sometimes takes much more pernicious forms. The same mentality cordons off HIV-positive persons in Cuba. It threatens the testing of international travelers before entry into a country even without commensurate attention to returning nationals. It creates barriers to human commerce and cultural exchange, and blights even our national approach to matters such as workplace safety. [For instance, even if every HIV-positive person were neurologically blighted - as they are not - their removal from industrial posts would account for only 1% of the safety-related hazards posed by illicit drugs and alcohol. And yet it is proposed - to quote one airline hell-bent on screening - that they will test for HIV "to assure absolute safety"!] The cultural pall threatened by repressive reactions to AIDS could indeed darken a future landscape.

Sometimes politicians complain that we are making an awful fuss over "just one disease" and that we are distorting priorities in the process. But it is terribly important to realize that the only thing really new about AIDS is the virus and the awful diseases it provokes; all the rest of the problems with which we are grappling is familiar turf

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AIDS in the Year 2000 (cont'd)

revisited; and perhaps we can devise fresh approaches to practical problems and can learn better ways to celebrate the diversity of humanity as we struggle together against the virus-enemy. I have been personally intrigued with the discovery that there are so many cross-cultural universals. The more divergent a culture is from my own, the more I am struck by common chords to which the human family resonates.

For instance, love of children is universal, as is some form of the perception that they embody our hopes for immortality. What differs is how readily we may sometimes forget that we feel that way; and there I think the so-called "developed" cultures might profit from the experience of other, less cluttered societies. We are also prone to forget that others feel at least as strongly as we do about children - resulting, for instance, in blithe assumptions and blind fiats that an HIV-infected woman should never get pregnant! - as if that were sufficient to settle the matter! In this epidemic it has been intriguing to watch public figures hug small children with AIDS in their effort to convey understanding and compassion - as I watch, I have pondered about what is the statute of limitations on childhood? When do we begin to revoke the permit for potential childishness and imperfection that stays with us, nevertheless, life-long.

The need for dignity is another feature that I think is absolutely universal, and in proportion to the extent that it is given or taken away, so waxes or wanes our capacity to help - and especially to educate. A stranger who strips away one's dignity at the very outset surely cannot safely be considered a friend. As we design interventions for health care and social support of persons who are progressively hampered by this awful virus and its diseases, the very feasibility of our innovations will rest on the remembrance of dignity as a determinant force. Again quoting Justice Michael Kirby, it makes little sense to refer to someone addicted to illicit substances as a "drug abuser" if we are trying to persuade them to let us into their lives.

Loyalty to loved ones is a complex, interesting universal. It can inspire wonderful feats of human courage and endurance, but it is also a force that drives men to war and causes people to lie, cheat and steal. In fact, it is protean in its perversions but, nonetheless, too strong to forget in our planning. I was fascinated by a complaint, registered recently by a colleague from a country in which frequent patronization of female prostitutes was a cultural force to be reckoned with. He noted with some despair that seropositive men were willing to follow through with partner notification when it came to extra-marital partners and yet refused to notify their wives! How complicated that is! - and yet we must not underestimate, or fail to learn the meaning of, the powerful

twisted loyalties that are expressed in such a quixotic distinction, if we are going to be able to deploy our knowledge to stop this epidemic.

All of these social and cultural forces that will help to determine in the tasks of the year 2000 will be collated by the political process, so it is important before closing to pay due respect to what is involved there. To do so I will revisit a talk I gave to the Conference of (U.S.) Mayors meeting on AIDS that was held in New York City in October 1987. (In fact, it was at lunch on Black Monday, and I was Mayor Koch's luncheon partner - talk about memorable!) I was trying to convey my awareness that most of my listeners were politicians and that I didn't envy them their tasks with respect to AIDS...as follows:

"The projected magnitude of the AIDS epidemic makes it an extraordinarily important matter for politicians to address; and yet as political problems go it is hard to imagine how things could be worse - just look at the array of potent emotional issues which interface with efforts at derivation of thoughtful policies and programs!

"To list just a few of those confounding elements: the AIDS epidemic has stimulated an astonishingly virulent homophobia. It thrives on illicit drug use and begs politically awkward questions as to the merits of methadon maintenance and facilitation of needle access. It comes on the heels of a strident anti-drug campaign [that] did not address treatment but rather wrapped users and pushers and entrepreneurs alike in the same cloak of hostile rejection. It has uncovered ugly evidence that the world has not changed with respect to prostitution and the unflagging double standard that perpetuates it as a profession. And almost worst of all, it speaks aloud the forbidden name of bisexuality and provides unwelcome evidence of its universality across the myriad human cultures that are struggling to maintain their identity in our pluralistic society.

"Its restricted patterns of transmission allow the virus to thrive in a medium of alcohol excess or drug-obscured judgement...the epidemic is swelling the growing army of the destitute, adding progressive neurologic deterioration to the appalling mix of chronic alcoholism, chronic mental illness, homelessness and helplessness. And finally, it fuels a right-wing flair which in turn nourishes a public taste for conspiracy and serves as a convenient substitute for common sense and hard work. Common sense would tell us that authoritarian approaches have never served to govern human sexual behavior, that drug use is flourishing in the face of pre-existing legal sanctions, and that voluntary change in personal and private risky activities is what is needed to stop the spread of the AIDS virus; but the idealogues imply with their categorical solutions that such change can be accomplished by fiat and decree..

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AIDS in the Year 2000 (cont'd)

"[But] we are by no means alone with this problem...It is a global problem and will never again be gone! The world changed with the appearance of the virus of AIDS: a new microbiological bomb has been detonated in our midst, and, like the advent of Hiroshima, the human immunodeficiency virus is a fact of life now for the whole human family, and we must learn to deal with it for the sake of our children's children."

At the end of that speech I used a quotation from Camus' The Plague that must, by now, have become almost tiresomely familiar to toilers in the fields of AIDS - but it serves well here: the conclusion of the doctor that "what we learn in time of pestilence [is] that there are more things to admire in men than to despise." The first years of the AIDS epidemic have underscored that, and the shadows of grief have been relieved by flashes of great humanity. It is the fate of many generations never to recognize greatness in their midst, or to do so only vaguely. By contrast we have had the privilege of knowing in the thick of social battle that we are in the company of heroes of our time - my friend Jonathan Mann, Director of the Global Program on AIDS at the World Health Organization, is a wonderful case-in-point, and a number of others are here today - and the common themes of myriad cultures give us new ways to learn to admire, and not despise! I am an inveterate optimist, and so you will forgive me if I conclude that way. The counterpoint of that heroism assures that the landscape of 2000 will not be desolate, that the dreadful AIDS snapshot already taken could turn out to be the ugliest of them, the tragic denouement of a rigorous twentieth century lesson in hubris and humility. At least there is a lot to be done - and perhaps, just barely, enough time to do it.

AIDS AND A MIRACLE

(By Rev. Elder Nancy Wilson)

Several weeks ago the lead story on a local Los Angeles news station was that Cedars Sinai hospital announced that they had discovered that the aids virus is at least one thousand times as deadly and powerful as they had once thought.

I knew it! I already knew that, I thought. I felt rage well up once again in me! Yes, we've known this all along, one thousand times more deadly, indeed.

As many of you know, I fasted from September 17 to October 15, 1989, while living at our new church building in Culver City. The purpose of the fast was to not lose the property, the ground, that would house our new home; and to raise the in-kind donations and money needed to occupy and finish the building.

But I also know that I was fasting to help me focus on my own ministry and leadership at MCC Los Angeles, and the Fellowship. I was fasting to improve with God's help, permanently, the quality of my life and ministry. So that God could have more of my undivided attention.

Early on in the fast I knew I was also fasting about aids. Cedars Sinai had not made their announcement yet, but it had been my experience that this virus was incredibly, devastatingly resistant to our most intense, fervent prayers for healing. Yes, there have been some miracles! But my soul says not enough, and not soon enough. Why? Surely it is not the will of God for so many to suffer so much, for so many to die so young, so soon. Surely, God is calling MCC to be in the vanguard for a healing flood, a healing movement. I felt that at the last General Conference. And yet, there is this horrifying resistance. That resistance is both out there, external, and within us in the form of despair.

I've shared this story in other contexts, but it bears repeating here. About 2 years ago I remember visiting my friend Rick, who worked across the hall from the UFMCC Offices. From more than 30 or 40 feet away, I could see that Rick was ill with aids. But something else happened that caught my attention. For an instant it was as if the virus itself spoke to me, mocked me, saying, "I've got another one!" It was an evil, chilling apparition - and suddenly it was gone. It frightened me to my toes. I could hardly make myself walk over to Rick, though I finally did. I know that my personal pain, shock, anger could have created this "apparition" as a psychological projection. But I really don't believe that's what it was. It was an evil appearance, an attempt to frighten, harass, and discourage me. What it reinforced within me is the conviction that aids is a personal attack on me, as a leader and Pastor in UFMCC. It is a personal attack on your ministry and mine. Your life and mine. It is not a natural disease. It is either a diabolic humanly engineered tool for holocaust or it is a gift from hell itself. In any case it is not just a disease like the common cold. It is not neutral! And, it is not a gift from God, or the will of God. It does not have the right to exist and to kill our people! It must be opposed, eradicated relentlessly. We must see this as a spiritual battle at the core.

We must prepare ourselves for intense, continuous battle. We must marshal every ounce of strength. We must get all the wisdom we can; we must do more than pray. We must take the authority of heaven, of Jesus, of the Holy Spirit, El Shaddai - take that authority and crush the virus. We must do that spiritually, morally and physically. We must devote our lives to that calling - put ourselves - like the priests of Israel between our people and this disease.

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Some of us must take on this powerful deadly disease - "armoured with all Christ-like graces" and resist it to the death.

In every attempt to heal, the disease has pushed back hard. We have to be prepared for that. To take this means to invite more suffering at first, more danger and spiritual challenge. We must say "God, call another church, another people - meanwhile we'll just hold peoples' hands, numbly bury the dead, keep trudging on faithfully, depressed and overwhelmed." - or we must stop in our tracks and say, "God here we stand - help us defeat this deadly assault of your enemy in this world."

Aids is not and probably will not spread virulently in the white, privileged, heterosexual community. It will continue to ravage gay men, IV drug users, those women and men infected by contaminated blood supplies, the poor, children of color, and the Third World. Those with the power, money and resources to intervene with adequate research and care have not, and, most likely, will not intervene.

So we must act-up. Especially spiritually. We saw the Holy Spirit of God come upon us in power at the business meeting in General Conference last summer when we broke through one more layer of corporate denial about how aids is devouring us.

I have had two people confirm a picture God gave me of someone in MCC just walking into a hospital or hospice and people being dramatically healed. I know that this could happen! Signs, wonders and miracles are aching and longing to burst upon us, to happen through us. We have to be bold innovative, willing and ready.

UCLA SURVEY SEEKING BLACK MEN

BLACK C.A.R.E. (Community AIDS Research & Education) is conducting an anonymous, national survey of Black gay or bisexual men (or any Black man who has had sex with men.) Black men who are interested in filling out this survey, which is sponsored by the Psychology Department of UCLA, should:

- * Request a questionnaire by mail from Dr. Vickie Mays, BLACK C.A.R.E. Project, 1283 Franz, Los Angeles, CA 90024.
- * Call Dr. Mays at 213/206-5162 and leave your name and address (kept strictly confidential; only Dr. Mays has access to the phone and the information). All questionnaires are already postage paid.
- * Get a number of surveys from the same address or phone to distribute in your community or through your church.

BLACK C.A.R.E. is a project committed to the fight against AIDS in the Black community.

AIDS MINISTRY HIGHLIGHTS

From Local Metropolitan Community Churches

[EDITOR'S NOTE: From time to time ALERT will feature information on local church AIDS ministries. This month provides an overview of some activities in the greater Los Angeles area. If you would like to share information on your AIDS ministry, please send it to ALERT, 5300 Santa Monica Blvd., #304, Los Angeles, CA 90029.]

MCC Los Angeles (Culver City): MCCLA has had an AIDS Ministry active for 3½ years. Pastoral/peer support, spiritual counseling and bereavement support and counseling, hospital/home visitation as well as other services are provided. MCCLA supplies food and other essentials to individuals and hospices, particularly. They serve approximately 6 to 20 people per month in their ministries. Early in 1990, Care for Babies With AIDS, a foster care facility, will be housed on the grounds of MCCLA's property. One student clergy with MCCLA is a chaplain at Chris Brownlie hospice. Rev. Wilson comments that she "feels very good about the relationships developed with hospitals and hospices."

[MCC Los Angeles, 5879 Washington Blvd., Culver City, CA 90232].

MCC of the Pomona Valley (Ontario): MCCPV's AIDS Ministry has been active for approximately 4 years and consists, primarily of hospital visitation, counseling and support. Other than their spiritual ministry, several members of the congregation serve on a committee which is developing a national program of insurance contributions to assist PWA's with the expense of hospitalization. This program was conceived by staff at West Covina Hospital and MCCPV was invited into the development process.

[MCC of the Pomona Valley, 637 N. Park, Suite G, Pomona, CA 91768].

MCC Long Beach: MCC Long Beach has an AIDS Ministry which specializes in housekeeping. From cleaning to shopping, they assist PWA's in Long Beach, Torrance and Westminster. MCCLB also provides counseling upon request, hospital visitation and periodic support groups. They have major food drives twice a year and donate the food stuffs to Project Ahead. In December they donate "seed faith" money to different area AIDS programs. MCC is represented in the Interfaith AIDS Ministry, a sub-division of the Long Beach Ministerial Association.

[MCC Long Beach, 1231 Locust Avenue, Long Beach, CA 90813]

(Continued next page)

AIDS Ministry Highlights (Cont'd)

Divine Redeemer MCC (Glendale): Founded three years ago Divine Redeemer's AIDS Ministry, known as Missionaries of Mercy, cleans the homes of PWA's. Rev. Stan Harris says it's "our response to the capitalism around AIDS" in that the Missionaries of Mercy refuse any donations of cash. A core group of six persons and 12 to 13 volunteers clean twenty or more homes per month. Covering Glendale, Silverlake, Atwater and Los Feliz (generally) they clean for any PWA, especially those who have no one to do it for them. The Missionaries of Mercy do not proselytize, however, the core group considers this ministry a spiritual discipline which includes a regimen of morning and evening prayer. "We have had no burn-out nor have we lost a single member," said Rev. Harris.
[Divine Redeemer MCC, 346 Riverdale Drive, Glendale, CA 91204].

MCC in the Valley (North Hollywood): Light of Life, MCC in the Valley's AIDS Ministry, is the only resource, religious or secular, serving the San Fernando Valley. Founded two years ago, they provide direct services with an ecumenical base. "Anyone learning to live with AIDS is ministered to," according to director Linda Ryan. Crisis intervention, peer listening and home/hospital visitation are all part of their outreach. "Caring Care Givers," support for anyone experiencing loss; and "People Together," support for those in the HIV infected community are two groups available with Light of Life. This year the Light of Life Center, a facility separate from MCCV's church grounds, opened and is being developed into a drop-in center, as well as housing a 24 hour hotline and other activities of the AIDS ministry.
[MCC in the Valley, 5730 Cahuenga Blvd., N. Hollywood, CA 91601].

UPCOMING CONFERENCE; AIDS, MEDICINE AND MIRACLES

Elizabeth Kubler-Ross will be the Keynote Speaker for the Third Annual AIDS, Medicine and Miracles Conference. The Conference will be held May 3-6, 1990 at the University of Colorado in Boulder. Fees: \$230 before February 28, \$255 after. "Immune Enhancing Lunches" available (3 for \$21). Scholarships are available for People Living with AIDS.

For registration or more information, contact:

AIDS Medicine and Miracles, Inc.
2033 - 11th Street, Suite #2
Boulder, Colorado 80302

or call: (303) 447-8777.

"TWELVE POSITIVE STEPS" NOW AVAILABLE

Health Crisis Network, Inc., of Miami, Florida has been given permission to reprint and distribute "Twelve Positive Steps," originally printed by the Illinois Alcoholism and Drug Dependence Association in April, 1988, as "Twelve Steps of HIVIES."

The booklet is a "step guide" to the 12 steps as rewritten specifically for people with HIV/AIDS. It is available by mail through the Health Crisis Network, Inc.

P.O. Box 42-1280
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The suggested contribution is \$6.00.